Commonwealth of Massachusetts
**MassHealth Drug Utilization Review Program**
P.O. Box 2586
Worcester, MA 01613-2586
**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

# G-CSF/GM-CSF Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for all G-CSF/GM-CSF products. Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**.

## Member information

| Last name | First name | MI | MassHealth member ID no. | Date of birth | Sex (Circle one.) f m |
|---|---|---|---|---|---|
| Member's place of residence | ☐ home ☐ nursing facility | | Height | Weight | |

## Medication information

| Drug name requested | Dose, frequency, and duration | Drug NDC (if known) or service code |
|---|---|---|

**Indication for G-CSF/GM-CSF** (Check one or all that apply):

☐ Autologous bone marrow transplant

☐ Chronic neutropenia

Etiology _____

☐ Peripheral blood progenitor cell collection and therapy

☐ Other (please explain):

☐ Drug induced neutropenia (Check one or all that apply.)

☐ Cancer chemotherapy:
Indicate type of cancer and chemotherapy regimen including dates, frequency, and duration.

☐ Hepatitis C
Indicate dates and current dosages of medication regimen.

Has dose adjustment been attempted?
(Check one or all that apply.):
☐ Yes. Please provide details.
☐ No. Explain why not.

☐ HIV
Is member currently receiving antiretroviral therapy?
(Check one or all that apply.):
☐ Yes. Please provide details.
☐ No. Explain why not.



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## Laboratory monitoring

Please provide date and results of the most recent CBC with differential or absolute neutrophil count (ANC).

## Pharmacy information

| Name | Pharmacy provider no. | Telephone no. ( ) | Fax no. ( ) | |
|---|---|---|---|---|
| Address | | City | State | Zip |

## Prescriber information

| Last name | First name | MI | MassHealth provider no. | DEA no. | |
|---|---|---|---|---|---|
| Address | | | City | State | Zip |
| E-mail address | | | Telephone no. ( ) | Fax no. ( ) | |

## Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date